STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN009554	A. BUILDING: _____ B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIGHTINGALE HOME HEALTHCARE INC	1036 S RANGELINE RD CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a State home health re-licensure survey. Survey Dates: 2-4-14, 2-5-14, 2-6-14, 2-7-14, 2-10-14, 2-11-14, and 2-12-14 Facility #: 009554 Medicaid Vendor #: 200107010 Surveyors: Vicki Harmon, RN, PHNS Team leader Tonya Tucker, RN, PHNS Eric Moran, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN February 21, 2014 This survey was modified as the result of an IDR 4/23/14. je	N 000		
N 462	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. This RULE is not met as evidenced by: Based on personnel file and agency policy review and interview, the agency failed to ensure all employees had a physical exam within 180 days	N 462		3/18/14

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N 462	Continued From page 1 of first patient contact in 1 of 12 personnel files reviewed (file H) with the potential to affect all the agency's patients that receive physical therapy services from employee H. Findings include: 1. The agency's undated policy titled "Standard HH4-1A.01 Standard HH4-1A.02" states,"Personnel File Contents ... Separate Confidential Files ... Medical/Health File Medical History Form." 2. Personnel file H, date of hire 8/5/13 and first patient contact 8/17/13, failed to evidence a physical examination had been completed less than 180 days from the date of first patient contact. 3. During an interview on 2/12/14 at 11:10 AM, Employee P, Human Resources, indicated employee H had a physical exam when they worked for Nightingale in California. Employee P further indicated employee H did not get a current physical exam when transferring to Indiana.	N 462		
N 470	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This RULE is not met as evidenced by: Based on observation, interview, and agency policy review, the agency failed to ensure its staff had provided services in accordance with its own infection control policies in 4 (patients # 1, 3, 19,	N 470		3/18/14

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N 470	Continued From page 2	N 470		

& 20) of 10 home visit observations completed creating the potential to affect all of the agency's 768 current patients.

The findings include:

1. The agency's undated Standard HH7-1A.01 "Hand Hygiene" states, "Always follow Standard Precautions."

The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially

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infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.

2. A home visit was made to patient number 1 on 2-6-14 at 9:15 AM with employee J, a home health aide. The aide was observed to provide a bed bath to the patient. The aide was observed to complete the bed bath by cleansing the patient's rectal area with moistened cleansing wipes. The aide changed her gloves without cleansing her hands. The aide then washed the patient's front perineal area and buttocks and changed the bath water. The aide was observed to change her gloves without cleansing her hands.

3. A home visit was made to patient number 19 on 2-6-14 at 12:10 PM with employee O, a physical therapist. The therapist was observed to touch the patient multiple times and touch her computer keyboard after touching the patient. When the therapist had completed the treatment, she reached into her bag, without cleansing her hands, and retrieved a pair of gloves. This created the potential for the transfer of disease causing organisms from the patient to the inside of the therapist's bag. She donned the gloves without cleansing her hands and cleaned her equipment, including the computer keyboard.

4. The home visit observations for patients 1 and 19 were presented to the Clinical Nursing Supervisor and the Assistant Nursing Supervisor on 2-10-14 at 3:15 PM. The individuals agreed the employees had not followed the agency's policy regarding Standard Precautions.

5. During the home visit to patient #20 on 2/6/14 at 2:30 PM, with employee M, a Licensed

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Practical Nurse (LPN), the nurse was observed to cleanse her hands with hand sanitizer, don clean gloves, and remove the dressing from the left hip. The LPN asked about the patient's pain and removed her gloves. The LPN then cleansed her hands with hand sanitizer, donned clean gloves, and sprayed the patient's wound with wound cleanser. The LPN patted the wound with gauze. Without changing her gloves or cleansing her hands, the LPN poured the prescribed Dakins solution onto gauze and applied the solution to the patient's wound. With the same gloves on, the LPN applied a new dressing to the wound.

During an interview on 2/10/14 at 3:26 PM, employee A, Alternate Nursing Supervisor, indicated employee M, the LPN, needed to cleanse her hands and don new gloves between cleansing the wound with wound spray and applying the Dakins solution.

6. During the home visit to patient #3, on 2/7/14 at 9:35 AM, employee N, a Registered Nurse (RN), was observed to perform a wound vacuum dressing change to the patient's left foot. The RN cleansed her hands with hand sanitizer, opened her Nightingale field staff bag, and retrieved supplies from the bag. Without cleansing her hands, the RN donned clean gloves, and began to cut strips of adhesive she had obtained from the patient's supply. The RN then applied the adhesive strips to the patient's foot / wound site.

A. Within the same home visit, the RN began to prepare for the Unasyn intravenous infusion. The RN cleansed her hands with hand sanitizer, threw away trash / supply wrappers, and retrieved supplies from the patient's home supply box. Then the RN placed clean gloves on the patient's couch without a protective barrier underneath the

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gloves. The RN cleansed her hands and donned the gloves that had been placed on the couch surface creating the potential for the transfer of disease causing organisms from the patient's couch surface to the clean gloves.

B. During an interview on 2/10/14 at 3:35 PM, employee A, Alternate Nursing Supervisor, indicated she noticed the gloves lying on the couch surface without a protective barrier underneath them. Employee A agreed that the RN opened the Nightingale field staff bag and needed to cleanse her hands before donning her gloves.

7. During the home visit to patient #3, on 2/7/14 at 9:35 AM, employee N, a Registered Nurse (RN), was observed to perform a wound vacuum dressing change to the patient's left foot. The RN cleansed her hands with hand sanitizer, opened her Nightingale field staff bag, and retrieved supplies from the bag. Without cleansing her hands, the RN donned clean gloves, and began to cut strips of adhesive she had obtained from the patient's supply. The RN then applied the adhesive strips to the patient's foot / wound site.

A. Within the same home visit, the RN began to prepare for the Unasyn I.V. infusion. The RN cleansed her hands with hand sanitizer, threw away trash / supply wrappers, and retrieved supplies from the patient's home supply box. Then the RN placed clean gloves on the patient's couch without a protective barrier under the gloves. The RN cleansed her hands and donned the gloves that had been placed on the couch surface creating the potential for the transfer of disease causing organisms from the patient's couch surface to the clean gloves.

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N 470	Continued From page 6 B. During an interview on 2/10/14 at 3:35 PM, employee A, Alternate Nursing Supervisor, indicated she noticed the gloves lying on the couch surface without a protective barrier under them. Employee A agreed the RN opened the Nightingale field staff bag and needed to cleanse her hands before donning her gloves.	N 470		
N 484	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. This RULE is not met as evidenced by: Based on clinical record and policy review, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 20 clinical records reviewed creating the potential to affect all patients receiving more than one. (#6) Findings include: 1. Clinical record #6 included a physician's plan of care for the certification period 12/28/13 to 2/25/14 with a principal diagnosis of "Open wound of hip and thigh with complications." The plan of care included orders for skilled nursing, 1 time a day for 1 day (12/28/13 to 12/28/13), 7 times per week for 2 weeks (12/31/13 to 1/11/14)	N 484		3/18/14

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N 484	Continued From page 7 and 2 times per week for 7 weeks (1/12/14 to 2/25/14), PT [physical therapy] 1 time a week for 1 week (12/29/13 to 1/4/14) for PT evaluation, and occupational therapy [OT] services, 1 time a week for 1 week (12/29/13 to 1/4/14) for OT evaluation. The plan of care listed employee D (registered nurse) as the case manager. The plan of care failed to evidence any communication among the skilled nurse, case manager, PT, and OT. 2. The undated policy titled "STANDARD HH5-4A STANDARD HH5-8A STANDARD HH5-8B" states, "STANDARD: All personnel involved in the patient's care are responsible for coordinating care effectively to support the objectives outline in the patient's plan of care. ... PURPOSE: To promote the effectiveness of patient care management, the organization and delivery of care, treatment and services, and the ability to evaluate patient outcomes. To provide a systematic process for planning and providing patient care, treatment and/or services that reflects the assessment data provided by members of the interdisciplinary team. To assure that patient care needs are being addressed adequately and appropriately. ... To promote effective coordination of care, treatment and/or services through collaboration among members of the interdisciplinary team. ... POLICY: ... All personnel involved in the patient's care are responsible for coordinating care effectively. Documentation of care coordination is expected minimally every 30 days." 3. The undated policy titled "Standard HH5-11A Standard HH5-11B" states, "STANDARD: The Agency defines the duties of the Registered Nurse and ensures they are implemented in patient care. ... PURPOSE: ... To maintain	N 484		

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N 484	Continued From page 8 effective channels of communication with the patient, physician, and other organizations and providers within the health care community. ... SERVICES/TREATMENTS PROVIDED: ... Performing skilled services in accordance with physician orders including but not limited to: wound care, ... injections, ... Coordination of care, treatment and/or services FUNCTIONS OF THE REGISTERED NURSE: ... Ensures coordination of patient care, treatment and/or services reviews and updates the plan of care as needed, but no less frequently than every 60 days."	N 484		
N 522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 6 (#s 4, 6, 8, 9, 13, and 16) of 20 records reviewed creating the potential to affect all of the agency's 768 current patients. The findings include: 1. Clinical record number 8 included a plan of care established by the physician for the certification period 12-18-13 to 2-15-14 that identified an occupational therapy (OT) evaluation was to be provided. The record failed to evidence the OT evaluation had been completed.	N 522		3/18/14

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N 522	Continued From page 9 The Director of Clinical Services indicated, on 2-11-14 at 2:20 PM, the OT evaluation had not been completed. The plan of care evidenced the skilled nurse was to "Prefill Medication Containers." Skilled nurse (SN) visit notes, dated 1-28-14, failed to evidence the SN had filled the medication containers as ordered. The Director of Clinical Services indicated, on 2-11-14 at 2:20 PM, the SN visit notes did not evidence the SN had filled the medication containers as ordered and needed. 2. Clinical record number 9 included a SN visit note dated 12-1-13 that evidenced the licensed practical nurse (LPN), employee M, had applied Silvadene cream to a burn wound on the patient's left thigh. A SN visit note dated 12-4-13 evidenced the SN had cleaned the left thigh burn with soap and water and had applied a dry dressing. A. The record failed to evidence an order for the application of the Silvadene cream or for the wound to be cleaned with soap and water. B. The Director of Clinical Services stated, on 2-11-14 at 12:50 PM, "The patient went to the ER on 11-29-13. That is where the Silvadene cream must have come from. The physician made a home visit and orders were received on 12-6-13 for the wound care." The Director indicated the record did not include an order for the application of the Silvadene cream or the cleansing of the wound with soap and water. 3. Clinical record number 13 included a plan of care established by the physician for the certification period 12-8-13 to 2-5-14 that	N 522		

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identifies the SN was to "Perform Ostomy Care."

A. The agency's 5-1-13 "Ostomy Care (SN)" procedure states, "Purpose: To provide safe and effective Ostomy care, including change of total appliance as needed." The procedure identifies 22 steps the SN is to perform to provide the ostomy care.

B. SN visit notes, dated 12-12-13, 12-18-13, 12-26-13, 1-1-14, 1-8-14, 1-15-14, 1-22-14, 1-24-14, and 1-29-14, failed to evidence the SN had performed the ostomy care.

C. The Assistant Director of Clinical Services stated, on 2-11-14 at 12:15 PM, "The nurse said the family had performed the ostomy care but that she did not document that."

4. The Director of Clinical Services was unable to provide any additional documentation and/or information related to the above-state findings when asked on 2-10-14 at 3:45 PM and on 2-12-14 at 11:55 AM.

5. The agency's undated Standard HHA-3A states, "Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine . . . All clinical services are implemented only in accordance with a plan of care established by a physician's written orders."

6. Clinical record #4, start of care 11/4/13, included a physician's plan of care for the certification period 1/3 to 3/3/14 with orders for occupational therapy 1 time per week for 1 week starting 1/14/14 to 1/18/14 and 2 times per week for 4 weeks starting 1/19 to 2/15/14. The record failed to evidence a second occupational therapy

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visit was made for week 4 and failed to evidence documentation of attempts to replace the discipline had been made.

On 2/12/14 at 9:39 AM, employee A (alternate director of nursing) indicated the visit was missed and was unable to locate documentation of attempts for a replacement and patient notification had been made prior to survey date.

7. Clinical record #6, start of care 2/28/13, included a physician's plan of care for the certification period 12/28/13 to 2/25/14 which states, "SN [skilled nursing] 1x/da [time per day] x 1 da (12/28/13 to 12/28/13), 7 x/wk [times per week] x 2 wks (12/31/13 to 1/11/14), 2 x/wk x 7 wks (1/12/14 to 2/25/14) ... Administer Tigechycline 100 mg [milligrams] via PICC through 1/9/14, PT: [physical therapy] 1x/wk x 1 wk (12/29/13 to 1/4/14) PT evaluation, OT: [occupational therapy] 1x/wk x 1 wk (12/29/13 to 1/4/14) OT evaluation."

A. The clinical record failed to evidence skilled nursing visits for antibiotic infusion were performed on 12/31/13, 1/3, 1/4, 1/5, 1/7, 1/8, and 1/9/14..

On 2/12/14 at 9:40 AM, employee B presented with hand written documentation of skilled nursing visits for 12/31/13, 1/3, 1/4, and 1/8/14. The employee indicated visits for dates of 1/5, 1/7, 1/9, and 1/11/14 had not been made.

B. The clinical record evidenced a PT visit on 1/31/14.

1). On 2/7/14 at 11:07 AM, employee B indicated the initial visit should have been made between the dates of 12/29/13 and 1/4/14.

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N 522	Continued From page 12 2). On 2/12/14 at 9:50 AM, employee B indicated this was the patient's initial physical therapy assessment. C. A document titled "Interim Orders" with a verbal order date of 1/3/14 and documented by employee S (OT) states, "Orders for discipline and treatments OT: 1x/wk x 8 wks (1/5/2014 to 2/25/2014)." 1). The clinical record evidenced the initial OT evaluation was made on 1/3/14 by employee S (OT). The record failed to evidence OT visits were made weeks 3, 4, 5, 6, and 7. 2). On 2/12/14 at 9:40 AM, employee B indicated the OT visits were missed due to not receiving insurance authorization for the visits. 8. Clinical record #16, start of care 8/18/13, included a physician's plan of care for certification period 12/17/13 to 2/14/14 with orders for skilled nursing services 2 times per week for 1 week starting 12/17/13 to 12/21/13 and then 3 times per week for 8 weeks starting 12/22/13 to 2/14/14 for assessment and wound care. The record failed to evidence a third visit was made for weeks 3 and 4. On 2/11/14 at 1 PM, employee B indicated skilled nursing only made 2 visits those weeks because the patient went to the wound clinic once for wound care and skilled nursing didn't need to provide wound care. 9. The undated agency policy titled "STANDARD HH5-2A.01 STANDARD HH5-2B STANDARD HH5-2C STANDARD HH5-2C.01 STANDARD HH5-2D STANDARD HH5-2E STANDARD	N 522		

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N 522	Continued From page 13 HH5-5A" states, "SUBJECT: THERAPY SERVICES PATIENT ASSESSMENT & PLAN OF CARE PURPOSE: To identify the patient's needs for care, treatment and/or services within an appropriate time frame based on the patient's needs and complexity of treatment, and in compliance with applicable laws, regulation and standards ... POLICY: ... If a service discipline cannot meet the time frame for assessment, the patient and the physician must be notified and orders received to delay the initial assessment/evaluation. Evaluation assessment findings will be documented whether or not services continue. ... ."	N 522		
N 524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment.	N 524		3/18/14

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N 524	Continued From page 14 (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all diagnoses, medications, durable medical equipment, and services in 8 (#s 6, 8, 11, 12, 15, 16, 17, and 18) of 20 records reviewed creating the potential to affect all of the agency's 768 total patients and failed to ensure orders for therapy services included specific treatment procedures in 1 (# 8) of 16 records reviewed of patients that received therapy services creating the potential to affect all of the agency's 558 current patients that receive therapy services. The findings include: Regarding orders for therapy services: 1. Clinical record number 8 included an "Interim Order" dated 11-9-13 that states, "ST 1w/wk x 4 wks [speech therapy 1 time per week for 4 weeks] (11-10-2013 to 12-7-2013)." The orders failed to include specific treatment procedures. 2. The Director of Clinical Services indicated, on 2-11-14 at 2:20 PM, the speech therapy orders did not include the specific procedures to be used. 3. The agency's undated Standard HH5-3A states, "The initial plan of care must include the following items . . . Orders for the amount, frequency and duration of specific home health services and disciplines, treatment, and procedures."	N 524		

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N 524	Continued From page 15 Regarding content of the plan of care: 1. Clinical record number 8 included a "Patient Note" dated 12-19-13 that states, "Over the past 60 days pt [patient] has received HCA [home care aide] services through CHOICE [another payer source] in addition to OT/ST/SN/HCA through Medicare." The plan of care for the certification period 10-19-13 to 12-17-13 failed to include the home care aide services provided through the other payer source. 2. Clinical record number 11 included a plan of care established by the physician for the certification period 1-28-14 to 3-28-14 that identified a secondary diagnosis of "Total Knee Replacement." The plan of care failed to evidence the correct surgical procedure. A. The start of care comprehensive assessment, completed by the registered nurse, employee R, dated 1-28-14, evidenced the patient has a "surgical wound left ankle." The initial physical therapy evaluation dated 1-30-14 and completed by the physical therapist, employee S, on 1-30-14, included a description of a left ankle surgical wound. A home visit was made to the patient on 2-6-14 at 1:05 PM with the physical therapist, employee T. The patient indicated the patient had a left total ankle joint replacement. Observation noted the patient had the left ankle elevated and the physical therapist performed physical therapy on the patient's left ankle. B. The record included a "Medication Form" completed at the start of care that evidenced Warfarin 6 milligrams was taken by the patient on	N 524		

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N 524	Continued From page 16	N 524		

Sunday, Monday, Tuesday, Thursday, Friday, and Saturday and that Warfarin 9 milligrams was taken every Wednesday. The plan of care for the certification period 1-28-14 to 3-28-14 stated, "Warfarin 6 milligram oral every day."

3. Clinical record number 12 included a "Medication Form" completed at the start of care on 2-3-14. The form listed Amlodipine 5 milligrams every day. The plan of care failed to include the Amlodipine.

The Director of Clinical Services indicated, on 2-11-14 at 2:30 PM, the plan of care did not include the Amlodipine.

4. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked about the above-stated findings on 2-10-14 at 3:45 PM.

5. The agency's undated Standard HH5-3A states, "The initial plan of care must include the following items: . . . principle and other pertinent diagnoses, Medications, including dose, frequency, and route, and whether the medications are new or changed . . . Orders for the amount, frequency and duration of specific home health care services and disciplines, treatment, and procedures."

6. Clinical record #6 included a physician's plan of care for the certification period 12/28/13 to 2/25/14 with a principal diagnosis of "Open wound of hip and thigh with complications". The plan of care included orders for skilled nursing, 1 time a day for 1 day (12/28/13 to 12/28/13), 7 times per week for 2 weeks (12/31/13 to 1/11/14) and 2 times per week for 7 weeks (1/12/14 to 2/25/14), PT [physical therapy] 1 time a week for

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N 524	Continued From page 17 1 week (12/29/13 to 1/4/14) for PT evaluation, and OT [occupational therapy] services 1 time a week for 1 week (12/29/13 to 1/4/14) for OT evaluation. A. The record contained a comprehensive assessment dated 2/28/14 by a registered nurse, employee R, stating on page 11 of 29, "Integumentary/ Skin status ... (wound) detailed wound assessment indicated? '0-No Wounds'.", and on page 12 of 29, "Does this patient have a surgical wound ? 'NO' ... Does this patient have a skin lesion or open wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency? 'NO' ... ." B. On 2/7/14 at 10:15 AM, employee B indicated the principal diagnosis on the plan of care said "Open Wound." C On 2/7/14 at 10:30 AM, employee B indicated the wound on the left hip was healed as of 12/23/13. D. On 2/12/14 at 9:40 AM, employee B presented a physician's verbal order, received by the employee on 2/7/14, stating, "Principal Diagnosis Postsurgical States Nec ... ." The employee indicated this should have been the principal diagnosis on the original plan of care dated 12/28/13. The order also listed "Personal history of Methicillin resistant Staphylococcus aureus" under "Other Pertinent Diagnoses." 7. Clinical record #15, start of care 12/3/13, included a plan of care for the certification period 12/6/13 to 2/3/14. The plan of care failed to include all durable medical equipment or supplies needed.	N 524		

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N 524	Continued From page 18 A. On 2/6/14 at 11:30 AM, during a home visit, the patient was observed using a walker. B. On 2/6/14 at 11:40 AM, employee B indicated the walker was not listed on the plan of care and should be listed under #14, "DME [durable medical equipment]and Supplies" or #18, "Activities Permitted." 8. Clinical record #16, start of care 8/19/13, contained a physician's plan of care for certification 12/17/13 to 2/14/14 signed and dated by a physician on 1/3/14. The physician signing the plan of care was not listed as the patient's physician on the plan of care. The clinical record failed to evidence documentation of knowledge of or a change in primary physicians. On 2/11/14 at 1 PM, employee B indicated the patient's case manager, employee I, was aware another physician would be taking over the patient's care soon after admission to home care services in August 2013 due to the primary physician moving. The employee indicated he/she was unable to locate documentation the case manger reported the change of physician to the agency. 9. Clinical record #17, start of care 12/21/13 , included a plan of care for the certification period 12/21/13 to 2/8/14. The plan of care failed to include all durable medical equipment or supplies needed. On 2/6/14 at 2:20 PM, during a home visit, the patient was observed using an O2 Concentrator. 10. The undated agency policy titled "Standard	N 524		

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N 524	Continued From page 19 HH5-3A Standard HH5-3B Standard HH5-5A Standard HH5-5B Standard HH5-9A" states, "Standard: There is a written plan of care for each patient accepted to services. ... Procedure: ... The initial plan of care must include the following items: ... Principle and other pertinent diagnoses ... Equipment and supply needs ... ."	N 524		
N 527	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the physician was notified of a change in condition for 1 of 20 records reviewed with the potential to affect all patients with a change in condition. (#18) Findings include: 1. Clinical record # 18, start of care 11/21/13, included a Skilled Nursing Clinical Note dated 12/20/13 that evidenced the Registered Nurse found a skin tear on the left hand between the thumb and index finger. The record failed to evidence the MD was notified or updated on the new skin tear. 2. During an interview on 2/12/14 at 10:03 AM, employee B, Nursing Supervisor, indicated there was no documentation to support the physician was notified of the new skin tear.	N 527		3/18/14

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N 537	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 5 (#s 6, 8, 9, 13, & 16) of 20 records reviewed creating the potential to affect all of the agency's 579 current patients that receive skilled nursing services. The findings include: 1. Clinical record number 8 included a plan of care established by the physician for the certification period 12-18-13 to 2-15-14 that evidenced the skilled nurse was to "Prefill Medication Containers." A. Skilled nurse (SN) visit notes, dated 1-28-14, failed to evidence the SN had filled the medication containers as ordered. B. The Director of Clinical Services indicated, on 2-11-14 at 2:20 PM, the SN visit notes did not evidence the SN had filled the medication containers as ordered and needed. 2. Clinical record number 9 included a SN visit note dated 12-1-13 that evidenced the licensed practical nurse (LPN), employee M, had applied Silvadene cream to a burn wound on the patient's left thigh. A SN visit note dated 12-4-13 evidenced the SN had cleaned the left thigh burn with soap and water and had applied a dry dressing.	N 537		3/18/14

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N 537	Continued From page 21 A. The record failed to evidence an order for the application of the Silvadene cream or for the wound to be cleaned with soap and water. B. The Director of Clinical Services stated, on 2-11-14 at 12:50 PM, "The patient went to the ER on 11-29-13. That is where the Silvadene cream must have come from. The physician made a home visit and orders were received on 12-6-13 for the wound care." The Director indicated the record did not include an order for the application of the Silvadene cream or the cleansing of the wound with soap and water. 3. Clinical record number 13 included a plan of care established by the physician for the certification period 12-8-13 to 2-5-14 that identifies the SN was to "Perform Ostomy Care." A. The agency's 5-1-13 "Ostomy Care (SN)" procedure states, "Purpose: To provide safe and effective Ostomy care, including change of total appliance as needed." The procedure identifies 22 steps the SN is to perform to provide the ostomy care. B. SN visit notes, dated 12-12-13, 12-18-13, 12-26-13, 1-1-14, 1-8-14, 1-15-14, 1-22-14, 1-24-14, and 1-29-14, failed to evidence the SN had performed the ostomy care. C. The Assistant Director of Clinical Services stated, on 2-11-14 at 12:15 PM, "The nurse said the family had performed the ostomy care but that she did not document that." 4. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2-10-14 at 3:45 PM	N 537		

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N 537	Continued From page 22 and on 2-12-14 at 11:55 AM. 5. The agency's undated Standard HHA-3A states, "Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine . . . All clinical services are implemented only in accordance with a plan of care established by a physician's written orders." 6. Clinical record #6, start of care 2/28/13, included a physician's plan of care for the certification period 12/28/13 to 2/25/14 which states, "SN [skilled nursing] 1x/da [time per day] x 1 da (12/28/13 to 12/28/13), 7 x/wk [times per week] x 2 wks (12/31/13 to 1/11/14), 2 x/wk x 7 wks (1/12/14 to 2/25/14) ... Administer Tigechycline 100 mg [milligrams] via PICC through 1/9/14, PT: [physical therapy] 1x/wk x 1 wk (12/29/13 to 1/4/14) PT evaluation, OT: [occupational therapy] 1x/wk x 1 wk (12/29/13 to 1/4/14) OT evaluation." A. The clinical record failed to evidence skilled nursing visits for antibiotic infusion were performed on 12/31/13, 1/3, 1/4, 1/5, 1/7, 1/8, and 1/9/14.. B. On 2/12/14 at 9:40 AM, employee B presented with hand written documentation of skilled nursing visits for 12/31/13, 1/3, 1/4, and 1/8/14. The employee indicated visits for dates of 1/5, 1/7, 1/9, and 1/11/14 had not been made. 7. Clinical record #16, start of care 8/18/13, included a physician's plan of care for certification period 12/17/13 to 2/14/14 with orders for skilled nursing services 2 times per week for 1 week starting 12/17/13 to 12/21/13 and then 3 times per week for 8 weeks starting 12/22/13 to 2/14/14	N 537		

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for assessment and wound care. The record failed to evidence a third visit was made for weeks 3 and 4.

On 2/11/14 at 1 PM, employee B indicated skilled nursing only made 2 visits those weeks because the patient went to the wound clinic once for wound care and skilled nursing didn't need to provide wound care.

8. The undated policy titled "Standard HH5-11A Standard HH5-11B" states, "STANDARD: The Agency defines the duties of the Registered Nurse and ensures they are implemented in patient care. ... PURPOSE: To delineate the scope of services provided by the Home Health Care Nursing Services program offered by the agency. POLICY: The agency provides comprehensive home health care nursing services to patients under the direction of a registered nurse with sufficient education and experience in the scope of services provided by the agency. ... Home health nursing services are available 24 hours a day, 7 days a week as necessary to meet patient needs. ... GOALS To ensure that patients receive quality, comprehensive health care services from highly qualified, dedicated, proficient, and caring nursing personnel. ... To maintain effective channels of communication with the patient, physician, and other organizations and providers within the health care community. ...
SERVICES/TREATMENTS PROVIDED: Initial assessment and reassessment of patient needs and clinical status Development and implementation of plans of care in cooperation with the patient/family/caregiver Adherence to the physician's plan of treatment ... Performing skilled services in accordance with physician orders including but not limited to: wound care, ...

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N 537	Continued From page 24 injections, ... Coordination of care, treatment and/or services FUNCTIONS OF THE REGISTERED NURSE: ... Ensures coordination of patient care, treatment and/or services reviews and updates the plan of care as needed, but no less frequently than every 60 days provides and documents all nursing care and services in accordance with the plan of care, and informs other team member, including the physician of any changes in the patient's condition and/or needs ... ."	N 537		
N 541	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. This RULE is not met as evidenced by: Based on clinical record and agency policy review, the agency failed to ensure the registered nurse reevaluated the patients needs timely and the evaluation accurately reflected the patients' status in 5 (#s 5, 8, 9, 13, & 17) of 20 records reviewed creating the potential to affect all of the agency's patients receiving services longer than 60 days or who are hospitalized. The findings include: 1. Clinical record number 5 evidenced a start of care date of 10-5-11 and that the patient received services during the certification periods 9-24-13 to 11-22-13 and 11-23-13 to 1-21-14. The record failed to evidence the comprehensive assessment had been updated the last 5 days of	N 541		3/18/14

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N 541	Continued From page 25 the 9-24-13 to 11-22-13 certification period. A. The Director of Nursing was unable to provide any additional documentation and/or information when asked on 2-10-14 at 3:45 PM and just prior to the exit conference on 2-12-14 at 11:55 AM. B. The agency's undated Standard HH5-2A.0 states, "The comprehensive assessment is reviewed and updated as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than: Within the last five (5) days of the certification period unless there is a beneficiary elected transfer, significant change in the patient's condition resulting in a new case-mix assignment, or discharge and return to the same Agency during the 60-day episode." 2. Clinical record number 8 included a recertification comprehensive assessment completed by employee DD, a registered nurse (RN), on 12-13-13. The plan of care for the certification period 12-18-13 to 2-15-14 included diagnoses of diabetes mellitus type II and obesity. A. The assessment identified the patient's current pain level was an "8" and that the patient "complains of "generalized" pain. The "pain description", "occurs", "lasts", "interfere with", and "is exacerbated by" portion of the assessment had been left blank. B. The assessment identified the patient had a urethral catheter. The "number", "size", "balloon", "inflated to", "next change due on or about", and "insertion area" portion of the assessment had been left blank.	N 541		

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N 541	Continued From page 26 C. The assessment identified a "detailed nutritional assessment" and "detailed gastrointestinal assessment" were indicated. The "PO intake/24 hrs", "Meals/24 hrs", and type of diet portion of the assessment had been left blank. D. The assessment identified a "detailed musculoskeletal assessment" was indicated. The assessment failed to include a detailed musculoskeletal assessment. 4. Clinical record number 9 included a recertification comprehensive assessment completed by employee AA, a RN, on 1-24-14. The assessment identified the patient had a partial thickness pressure ulcer. The "wound size", "length", "width", and "depth" had been left blank. A. The assessment identified a "detailed nutritional assessment" and a "detailed gastrointestinal assessment" were indicated. The assessment indicated the patient was "following diet guidelines" but failed to identify what type of diet. The assessment identified the bowel evacuation pattern as "usual". The "stool color", "stool type", and "stool amt" had been left blank." B. The assessment identified a "detailed neurological assessment" was indicated. The "fine tremor", "gross tremor", "seizure", "hand grasps", and "pupils" portion of the assessment had been left blank. 5. Clinical record number 13 included a recertification comprehensive assessment completed by employee L, a registered nurse, on 12-4-13. The assessment identified a "detailed	N 541		

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gastrointestinal assessment" was indicated. The "PO intake/24 hrs", "Meals 24/hrs", bowel evacuation "pattern", "stool color", "stool type", "stool amt", and last BM portions of the assessment had been left blank.

A. The assessment identified the patient had a gastrointestinal ostomy. The "size" and details about the appliance had been left blank.

B. The assessment identified a "detailed mental status assessment" was indicated. The "short term memory", "long term memory", "eye contact", "pt appearance", "pt affect", "pt attitude", and "thought content" portion of the assessment had been left blank.

6. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2-10-14 at 3:45 PM and on 2-12-14 at 11:55 AM.

7. The agency's undated Standard HH5-2D states, "A Registered Nurse or Therapist if physician orders therapy only, shall complete a comprehensive assessment and reassessment of the patient's needs for care, treatment, and/or services . . . The Comprehensive Assessment: . . . Includes the following information: . . . physical health component which includes: . . . pain assessment including history and characteristics of pain, head to toe assessments . . . special nutritional needs or dietary requirements and weight loss, assessment of pain and other symptoms . . . other information that could impact the care/services required to meet the patient and family needs. Mental component which includes: Evaluation of the patient's orientation, memory, reasoning, judgement, emotional status, education level, ability to read, and language

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preference. Emotional/Behavioral status."

8. Clinical record #17, start of care 12/21/13, failed to evidence a comprehensive assessment had been completed in the required timeframe after the patient had been discharged from the hospital for treatment of shortness of breath.

A. The record contained a document dated 1/20/14 titled "Patient Note" which states, "Subject Call from daughter Note Received call from daughter [name] stating her [parent] has been admitted to [name of hospital] for shortness of breath. ... ."

B. The record contained a document dated 1/23/14 titled "Patient Note" which states, "Subject Patient Call Note ... Patient is home from the hospital."

C. A visit note electronically signed by employee I (registered nurse) on 1/27/14 states, "(ROC) [Resumption of Care] SN [skilled nursing] visit note."

9. The undated agency policy titled "STANDARD HH5-2A.01 STANDARD HH5-2B STANDARD HH5-2C STANDARD HH5-2C.01 STANDARD HH5-2D STANDARD HH5-2E STANDARD HH5-5A" states, "STANDARD: ... The comprehensive assessment is updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status ... POLICY: The comprehensive assessment is reviewed and updated as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than: ... within 48 hours of the patients

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N 541	Continued From page 29 return home following a hospital admission of 24 hours or more for any reason other than diagnostic tests; ... ."	N 541		
N 542	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had updated and revised the plan of care in 3 (#s 6, 9, and 16) of 20 records reviewed creating the potential to affect all of the agency's 579 current patients that receive skilled nursing services. The findings include: 1. Clinical record number 9 failed to evidence the RN had updated the plan of care to reflect the patient's current needs and status. A. The record included a plan of care established by the physician for the certification period 11-27-13 to 1-25-14 with diagnoses of "Quadriplegia, unspecified, Muscle weakness, HTN (hypertension), Atten [attention] to Colostomy, Atten to Urinostomy Nec." B. The plan of care included orders for the skilled nurse that state, "Wounds: all burn sites and R [right] donar [sic] site: sheet hydrogel, once all burn sites are covered secure with	N 542		3/18/14

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protective gauze dressing. Wounds: all burn sites and R donar site: sheet hydrogel, once all burn sites are covered secure with protective gauze dressing."

C. The recertification comprehensive assessment, dated 11-26-13, completed to provide information to prepare the 11-27-13 to 1-25-14 plan of care, states, "No wounds."

2. The Director of Clinical Services stated, on 2-11-14 at 12:50 PM, "The wounds were healed. The RN took the wound diagnosis off the plan of care but failed to remove the orders out of the plan of care."

3. The agency's undated Standard HH5-11A states, "Functions of the Registered Nurse: . . . Review and updates the plan of care as needed, but no less frequently than every 60 days."

4. Clinical record #6 included a physician's plan of care for the certification period 12/28/13 to 2/25/14 with principal diagnosis of "Open wound of hip and thigh with complications". The plan of care included orders for skilled nursing, 1 time a day for 1 day (12/28/13 to 12/28/13), 7 times per week for 2 weeks (12/31/13 to 1/11/14) and 2 times per week for 7 weeks (1/12/14 to 2/25/14), PT [physical therapy], 1 time a week for 1 week (12/29/13 to 1/4/14) for PT evaluation, and OT [occupational therapy] services, 1 time a week for 1 week (12/29/13 to 1/4/14) for OT evaluation. The plan of care listed employee D (registered nurse) as the case manager. The record failed to evidence the registered nurse updated and revised the plan of care.

A. On 2/7/14 at 10:12 AM, employee B indicated the patient was admitted with orders for

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dressing changes, wound care, and IV infusions. The employee indicated believing the wound was healed before admission on 12/28/14.

B. On 2/7/14 at 10:30 AM, employee B indicated the wound on the left hip was healed as of 12/23/13, before patient admission.

C. The clinical record contained documents pertaining to the hospital admission prior to admission on 12/28/13. The documents evidence the patient was receiving IV [intravenous] antibiotics for a MRSA [Methicillin Resistant Staphylococcus Aureus] infection of the left hip at time of discharge on 12/27/13 and the antibiotics were to be continued by home health services on a daily basis until 1/9/14.

On 2/12/14 at 9:40 AM, employee B presented a physician's verbal order, received by the employee on 2/7/14 stating, "Principal Diagnosis Postsurgical States Nec ... Other Pertinent Diagnoses ... Personal history of Methicillin resistant Staphylococcus aureus ... ." The employee indicated this should have been the principal diagnosis on the original plan of care dated 12/28/13.

5. Clinical record #16, start of care 8/19/13, contained a physician's plan of care for certification 12/17/13 to 2/14/14 signed and dated by a physician on 1/3/14. The physician signing the plan of care was not listed as the patient's physician on the plan of care. The clinical record failed to evidence documentation of knowledge of or a change in primary physicians. The record failed to evidence the registered nurse updated and revised the plan of care.

On 2/11/14 at 1 PM, employee B indicated

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N 542	Continued From page 32 the patient's case manager, employee I, was aware another physician would be taking over the patient's care soon after admission to home care services in August 2013 due to primary physician moving.	N 542		
N 545	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had coordinated care and services in 1 (#s 6) of 20 records reviewed creating the potential to affect all of the agency's patients that receive more than one service. The findings include: 1. Clinical record #6 included a physician's plan of care for the certification period 12/28/13 to 2/25/14 with a principal diagnosis of "Open wound of hip and thigh with complications." The plan of care included orders for skilled nursing, 1 time a day for 1 day (12/28/13 to 12/28/13), 7 times per week for 2 weeks (12/31/13 to 1/11/14) and 2 times per week for 7 weeks (1/12/14 to 2/25/14), PT [physical therapy] 1 time a week for 1 week (12/29/13 to 1/4/14) for PT evaluation, and occupational therapy [OT] services, 1 time a week for 1 week (12/29/13 to 1/4/14) for OT evaluation. The plan of care listed employee D (registered nurse) as the case manager. The plan of care failed to evidence any communication	N 545		3/18/14

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N 545	Continued From page 33 among the skilled nurse, case manager, PT, and OT. 2. The undated policy titled "STANDARD HH5-4A STANDARD HH5-8A STANDARD HH5-8B" states, "STANDARD: All personnel involved in the patient's care are responsible for coordinating care effectively to support the objectives outline in the patient's plan of care. ... PURPOSE: To promote the effectiveness of patient care management, the organization and delivery of care, treatment and services, and the ability to evaluate patient outcomes. To provide a systematic process for planning and providing patient care, treatment and/or services that reflects the assessment data provided by members of the interdisciplinary team. To assure that patient care needs are being addressed adequately and appropriately. ... To promote effective coordination of care, treatment and/or services through collaboration among members of the interdisciplinary team. ... POLICY: ... All personnel involved in the patient's care are responsible for coordinating care effectively. Documentation of care coordination is expected minimally every 30 days." 3. The undated policy titled "Standard HH5-11A Standard HH5-11B" states, "STANDARD: The Agency defines the duties of the Registered Nurse and ensures they are implemented in patient care. ... PURPOSE: ... To maintain effective channels of communication with the patient, physician, and other organizations and providers within the health care community. ... SERVICES/TREATMENTS PROVIDED: ... Performing skilled services in accordance with physician orders including but not limited to: wound care, ... injections, ... Coordination of care, treatment and/or services FUNCTIONS OF	N 545		

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N 545	Continued From page 34 THE REGISTERED NURSE: ... Ensures coordination of patient care, treatment and/or services reviews and updates the plan of care as needed, but no less frequently than every 60 days."	N 545		
N 546	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN), not the licensed practical nurse, had informed the physician of changes in the patients' needs and condition in 4 (#s 9, 10, 11, and 12) of 16 records reviewed creating the potential to affect all of the agency's 579 current patients that receive skilled nursing services. The findings include: 1. Clinical record number 9 evidenced documentation the LPN had notified the physician of changes in the patient's skin integrity and wound. A. A skilled nurse (SN) visit note, signed and dated by employee V, an LPN, on 1-8-14, states,	N 546		3/18/14

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N 546	Continued From page 35 "Client has new area on bottom, orders obtained from MD and called to case manager to place in POC [plan of care]." B. A SN visit note, signed and dated by employee W, an LPN, on 1-12-14, states, "Pt [patient] seen today r/t [related to] concerns about increased drainage to wound site . . . MD notified of SN findings. 0 new orders." 2. Clinical record number 10 evidenced the LPN had notified the physician of a change in the patient's urinary status and of blood test results. A. A SN visit note signed and dated by employee U, an LPN, on 1-14-14 states, "spoke with [name of physician] nurse received verbal order for u/a c & s [urinalysis, culture and sensitivity] to be collected, pt/inr [blood test] phoned in to [name of physician], clinical coordinator notified regarding the new order." B. A SN visit note signed and dated by employee U, and LPN, on 1-21-14 states, "pt 17.7 inr 1.8 results called in to [name of physician] office spoke to nurse." C. A SN visit note signed and dated by employee U, an LPN, on 2-4-14, states, "pt/inr performed pt 13.5 inr 1.4, called in to [name of physician] office spoke to [name] she stated that md was out of office this week, called [name of physician] office regarding ua c/s message left to return call to family or nightingale office." 3. Clinical record number 11 evidenced documentation the LPN had informed the physician of laboratory results. A. A SN visit note, signed and dated by	N 546		

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employee X, an LPN, on 1-29-14, states, "Call placed to [name of physician] and left results and that venapuncture [sic] was completed to confirm results and that results will be faxed to MD office."

B. A "Patient Note", signed and dated by employee X, an LPN, on 1-30-14 states, "Spoke with [name of physician] nurse who stated they had not received results. Informed her our office would fax results to MD office. Left my phone number with nurse to call if fax is not received."

4. Clinical record number 12 evidenced documentation the LPN had informed the physician of the patient's elevated blood pressure.

A SN visit note, signed and dated by employee U, an LPN, on 2-4-14, states, "assessment performed . . . bp 170/70 call md nurse stated would let me know and call nightingale office with any new orders."

5. During a home visit to patient number 12, on 2-6-14 at 10:20 AM, employee U, an LPN, stated, "I call the MD with problems and then call my case manager, an RN, and report. If the physician calls me with orders, I call the case manager and she puts in the orders." The LPN indicated she does not first call the supervising RN prior to notifying the physician of any changes in the patient's condition.

6. The agency's undated Standard HH5-11A states, "Functions of the registered nurse: . . . Provides and documents all nursing care and services in accordance with the plan of care, and informs other team members, including the physician, of any changes in the patient's condition and/or needs."

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N 559	410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the licensed practical nurse (LPN) had consulted with the supervising registered nurse (RN) prior to informing the physician of changes in the patients' needs and condition in 4 (#s 9, 10, 11, and 12) of 16 records reviewed of patients that received skilled nursing services from the agency creating the potential to affect all of the agency's 579 current patients that receive skilled nursing services. The findings include: 1. Clinical record number 9 evidenced documentation the LPN had notified the physician of changes in the patient's skin integrity and wound without first consulting with the supervising RN. A. A skilled nurse (SN) visit note, signed and dated by employee V, an LPN, on 1-8-14, states, "Client has new area on bottom, orders obtained from MD and called to case manager to place in POC [plan of care]." The record failed to evidence the LPN had consulted with the supervising nurse prior to informing the physician of the change in the patient's skin integrity. B. A SN visit note, signed and dated by	N 559		3/18/14

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N 559	Continued From page 38 employee W, an LPN, on 1-12-14, states, "Pt [patient] seen today r/t [related to] concerns about increased drainage to wound site . . . MD notified of SN findings. 0 new orders." The record failed to evidence the LPN had consulted with the supervising nurse prior to informing the physician of the change in the patient's wound. 2. Clinical record number 10 evidenced documentation the LPN had notified the physician of a change in the patient's urinary status and of blood test results without first consulting with the supervising nurse. A. A SN visit note signed and dated by employee U, an LPN, on 1-14-14 states, "Spoke with [name of physician] nurse received verbal order for u/a c & s [urinalysis, culture and sensitivity] to be collected, pt/inr [blood test] phoned in to [name of physician], clinical coordinator notified regarding the new order." B. A SN visit note signed and dated by employee U, and LPN, on 1-21-14 states, "pt 17.7 inr 1.8 results called in to [name of physician] office spoke to nurse." C. A SN visit note signed and dated by employee U, an LPN, on 2-4-14, states, "pt/inr performed pt 13.5 inr 1.4, called in to [name of physician] office spoke to [name] she stated that md was out of office this week, called [name of physician] office regarding ua c/s message left to return call to family or nightingale office." 3. Clinical record number 11 evidenced documentation the LPN had informed the physician of laboratory results without first consulting with the supervising RN.	N 559		

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N 559	Continued From page 39 A. A SN visit note, signed and dated by employee X, an LPN, on 1-29-14, states, "Call placed to [name of physician] and left results and that venapuncture [sic] was completed to confirm results and that results will be faxed to MD office." B. A "Patient Note", signed and dated by employee X, an LPN, on 1-30-14 states, "Spoke with [name of physician] nurse who stated they had not received results. Informed her our office would fax results to MD office. Left my phone number with nurse to call if fax is not received." 4. Clinical record number 12 evidenced documentation the LPN had informed the physician of the patient's elevated blood pressure without first consulting with the supervising nurse. A. A SN visit note, signed and dated by employee U, an LPN, on 2-4-14, states, "Assessment performed . . . bp [blood pressure] 170/70 call md nurse stated would let me know and call nightingale office with any new orders." B. During a home visit to patient number 12, on 2-6-14 at 10:20 AM, employee U, an LPN, stated, "I call the MD with problems and then call my case manager, an RN, and report. If the physician calls me with orders, I call the case manager and she puts in the orders." The LPN indicated she does not first call the supervising RN prior to notifying the physician of any changes in the patient's condition.	N 559		
N 570	410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may:	N 570		3/18/14

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N 570	Continued From page 40 (1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate. This RULE is not met as evidenced by: Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 2 (#s 5 and 18) of 14 records reviewed of patients that physical therapy services creating the potential to affect all of the agency's 520 current patients that receive physical therapy services. The findings include: 1. 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist of physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments." 2. The agency's undated Standard HH1-1C states, "The Agency will comply with the accepted professional standard and principles. The accepted professional standards and principles that the HHA and the staff must comply with will include, but are not limited to: . . . State Practice Act . . . HHA's own policies and procedures.	N 570		

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N 570	Continued From page 41 3. The agency's undated Standard HH5-11.D states, "Functions of the licensed physical therapist: . . . Supervision of the Physical Therapy Assistant . . . as well as review of patient records; and case conferences with the PTA . . . Functions of the physical therapy assistant: Provides services according to applicable laws, regulations and standards, the State's Physical Therapy Practice Act and the Agency's policies and job descriptions under supervision of the Physical Therapist. 4. Clinical record number 5 evidenced physical therapy services had been ordered by the physician 2 times per week for 4 weeks during the certification period 11-23-13 to 1-21-14. The record evidenced the PTA, employee Y, had provided services to the patient on 12-3-13, 12-4-13, 12-10-13, 12-12-13, 12-19-13, A. The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The record included a "Patient Note" dated 12-31-13 that states, "PTA communication for 12-3-13." B. The record included a "Patient Note" dated 12-29-13 that states, "Late entry: PTA supervisory visit for [employee Y] 12-18-13." C. The record included a "Patient Note" dated 1-1-14 that states, "PTA communication for 12-19-13." D. The record included a "Patient Note" dated 1-1-14 that states, "PTA communication for 12-10-13."	N 570		

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N 570	Continued From page 42 E. The record included a "Patient Note" dated 1-1-14 that states, "PTA communication for visit 12-4-13." F. The record included a "Patient Note" dated 2-11-14 that states, "PT-PTA communication for 12-12-13." 5. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2-10-14 at 3:45 PM and on 2-12-14 at 11:55 AM. 6. Clinical record number 18 evidenced services had been provided by the PTA on 1-9-14. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatment. During an interview on 2/12/14 at 10:47 AM, employee A, Alternate Nursing Supervisor, acknowledged the PT needs to improve communication with the PTA. Employee A further indicated she educated the PT to start communicating with the PTA and documenting communications daily.	N 570		
N 606	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. This RULE is not met as evidenced by: Based on clinical record and agency policy review	N 606		3/18/14

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N 606	Continued From page 43	N 606		

and interview, the agency failed to ensure the registered nurse or therapist had made a supervisory visit to the patient's home at least every two (2) weeks in 4 (#s 2, 5, 8, & 10) of 9 records reviewed of patients that received home health aide and skilled services creating the potential to affect all of the agency's 410 patients that received skilled services and home health aide services.

The findings include:

1. Clinical record number 5 evidenced home health aide services had been provided 3 times per week and skilled nursing had been provided 1 time per month during the certification period 11-23-13 to 1-21-14 and that physical therapy services had been provided 2 times per week for 4 weeks from 11-26-13 to 12-21-13.

The record evidenced a home health aide supervisory visit had been completed on 11-25-13 and not again until 12-23-13, a period of 28 days between supervisory visits.

2. Clinical record number 8 evidenced home health aide services had been provided 3 times per week and skilled nursing services 2 times per week during the certification period 12-18-13 to 2-15-14.

A. The record evidenced a home health aide supervisory visit had been completed on 12-24-13 and not again until 1-21-14, a period of 27 days between supervisory visits.

B. The Director of Nursing indicated, on 2-11-14 at 2:20 PM, aide supervisory visits had not been completed at least every 2 weeks.

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N 606	Continued From page 44 3. Clinical record number 10 evidenced home health aide services had been provided 1 time per week and skilled nursing had been provided 2 times per week during the certification period 1-7-14 to 3-7-14. The record failed to evidence a home health aide supervisory visit had been made until 1-30-14, a period of 23 days since the patient first received home health aide services. 4. The Director of Nursing was unable to provide any additional documentation and/or information when asked on on 2-10-14 at 3:45 PM, on 2-11-14 at 2:10 PM, and on 2-12-14 at 11:50 AM. 5. The agency's undated Standard HH5-4B.01 states, "All patients receiving aide services and skilled services shall receive a supervisory visit by a [sic] the RN (or therapist is [sic] therapy only case) every two (2) weeks." 6. Clinical record #2, start of care 6/22/13, included a plan of care with physicians orders for physical therapy services and home health aide services for certification period 12/19/13 to 2/16/14. The record failed to evidence supervisory visits were made by the physical therapist or a registered nurse from 12/12/13 to 1/23/14. On 2/11/14 at 1:45 PM, employee Z indicated the supervision of the home health aide should be every 30 days.	N 606		
N 608	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:	N 608		3/18/14

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N 608	Continued From page 45 (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This RULE is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record contained clinical notes and name of physician in accordance with accepted professional standards for every patient receiving home health services in 2 of 20 clinical records reviewed creating the potential to affect all 768 patients of the agency. (#6 and #16) Findings include: 1. Clinical record #6 included a physician's plan of care for the certification period 12/28/13 to 2/25/14 with orders for skilled nursing 1 time a day for 1 day (12/28/13 to 12/28/13), 7 times per week for 2 weeks (12/31/13 to 1/11/14) and 2 times per week for 7 weeks (1/12/14 to 2/25/14). The record failed to evidence skilled nursing visits for 12/31/13, 1/3, 1/4, 1/5, 1/7, 1/8, 1/9, and 1/11/14. A. On 2/7/14 at 10:44 AM, employee B indicated documentation of the visits for 12/29 and 12/31/13, 1/3, 1/4, 1/5, 1/7, 1/8, 1/9, and 1/11/2014 were not in the chart but had to be	N 608		

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paper documentation because they were awaiting authorization from the patient's insurance and the visits could not be documented electronically. The employee indicated he/she would contact staff and have them turn in any documentation of visits they have made.

B. On 2/12/14 at 9:40 AM, employee B presented with hand written documentation of skilled nursing visits for 12/29 and 12/31/13, 1/3, 1/4, and 1/8/14. The employee indicated visits for dates of 1/5, 1/7, 1/9, and 1/11/14 were not made.

2. Clinical record #16, start of care 8/19/13, contained a physician's plan of care for certification 12/17/13 to 2/14/14 signed and dated by a physician on 1/3/14. The physician signing the plan of care was not listed as the patient's physician on the plan of care. The record failed to evidence documentation of a change in primary physicians.

On 2/11/14 at 1 PM, employee B indicated the patient's case manager, employee I, was aware another physician would be taking over the patient's care soon after admission to home care services due to primary physician moving. The employee indicated he/she was unable to locate documentation of the physician change which occurred in August, 2013.

3. The undated agency policy titled, "Standard HH5-1A Standard HH5-1A.01" states, "STANDARD: There is a patient record for each individual who receives care/service that contains all required documentation. All entries are legible, clear, complete, and appropriately authenticated and dated in accordance with policies/procedures and currently accepted standards of practice. ... PURPOSE: To maintain

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complete and comprehensive patient records that are in compliance with applicable laws, regulations and standards, and Agency policy. ... POLICY: All patients receiving care, treatment and/or services from the agency shall have a medical record file (electronic medical record or paper chart) that contains the following information: ... Name, address and telephone number of physician responsible for care ... Ongoing assessments ... Evidence of coordination of service/care provided by the agency with others who might be providing patient care/service ... Clinical and progress notes that are dated and signed with the original, legible, legal signature and credentials of the clinician who provided the care, treatment and/or service ... Each home visit, treatment, or care/service provided shall be documented in the record and signed by the staff member who provided the service/care. ... ."

4. Clinical record #18, with a Start of Care date of 11/21/13, contained a Plan of Care for the certification period 11/21/13 - 1/19/14 and 1/20/14 - 3/20/14. The clinical record evidenced the following:

A. The Physical Therapy Clinical Note evidenced the Physical Therapist was last in the home on 1/7/14. The record failed to evidence Physical Therapy discharge documentation.

B. The Occupational Therapist was last in the home on 12/12/13. The record failed to evidence Occupational Therapy discharge documentation.

C. During an interview on 2/12/14 at 10:33 PM, employee A, Alternate Nursing Supervisor, indicated there was no Physical Therapy discharge paperwork. At 10:47 AM, employee B,

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N 608	Continued From page 48 Nursing Supervisor, indicated there was no Occupational Therapy discharge paperwork. 5. The agency's undated Standard HH5-1A states, "All patients receiving care, treatment and/or services from the Agency shall have a medical record file (electronic medical record or paper chart) that contains the following: . . . Discharge/transfer summary." The agency's undated Standard HH5-7A states, "The discharge summary should be completed by each skilled service and presented to the patient/family for signature on the day of discharge."	N 608		